

*POC accepted 10/15/09 B. Carrough HFS III*

PRINTED: 08/26/2009  
FORM APPROVED

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  NVN635HOS	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 07/02/2009
NAME OF PROVIDER OR SUPPLIER  CARSON TAHOE REGIONAL MEDICAL CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 1600 MEDICAL PARKWAY CARSON CITY, NV 89703		
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S 000	Initial Comments  This Statement of Deficiencies was generated as a result of complaint investigation conducted in your facility on 6/10/09 and finalized on 7/2/09, in accordance with Nevada Administrative Code, Chapter 449, Hospitals.  Complaint #NV00021724 was substantiated with deficiencies cited. See Tag Z 146.  The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.	S 000			
S 146 SS=G	NAC 449.332 Discharge Planning  4. An evaluation of the needs of a patient relating to discharge planning must include, without limitation, consideration of: (a) The needs of the patient for postoperative services and the availability of those services; (b) The capacity of the patient for self-care; and (c) The possibility of returning the patient to a previous care setting or making another appropriate placement of the patient after discharge. This Regulation is not met as evidenced by: Based on record review and interview the facility failed to ensure a thorough evaluation of the discharge needs, the capacity for self-care, and the provision of necessary durable medical equipment upon discharge for 1 of 5 patients. (Patient #1)  Findings include:  Patient #1 was admitted to the facility admitted to	S 146			

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CARSON CITY, NEVADA

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*Calvin Danner CNO*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE  
9-3-09

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S 146	<p>Continued From page 1</p> <p>the facility on 3/15/09 with diagnoses of hepatic encephalopathy, hepatitis with cirrhosis, history of frequent falls, history of recent fracture of proximal humeral diaphysis, anxiety disorder with claustrophobia, history of chronic pain syndrome, and history of depression. The initial discharge planning assessment was completed on 3/16/09. The original discharge plan was for skilled nursing facility (SNF) placement. Patient #1 refused SNF placement and alternate discharge planning began.</p> <p>Patient #1's record was reviewed and revealed a note that she "was admitted through the emergency room at (the facility) after being brought in with vague complaints of altered level of consciousness, left shoulder pain and generalized weakness. The patient had recently traveled here (Nevada) from California and was staying at a local motel for approximately two days prior to coming in. Apparently she had a couple of falls on her left shoulder in California and was diagnosed with a left proximal humeral diaphysis fracture."</p> <p>Patient #1's orders included orders for physical therapy (PT) and occupational therapy (OT) on her day of admission. Review of the PT and OT notes revealed the patient frequently declined to participate. The PT long term goal was to ambulate 50 feet with a front wheeled walker. PT discharged the patient from the service on 3/31/09 "due to continued refusal and lack of participation." The PT discharge note was written in the physician progress notes, and PT documented that nursing was aware of the discharge from PT services. She was discharged from OT on 4/7/09 for decreased motivation and participation. An order for PT/OT to evaluate and treat was written again on 4/7/07. Both PT</p>	S 146	<p>Plan of correction NV 00021724 Tag S146 Page 2 of 4 (a)</p> <p>Record review completed by the Manager of Integrated Care Management validates that the original discharge plan did include skilled nursing facility placement for the patient and that the patient refused this placement. Additionally, the patient received a psychiatric evaluation on 3/26/2009. It was determined that she was capable of making her own decisions. Not only did she refuse SNF placement, but it is documented that she also refused to use her SSI monies to pay for alternative care, such as a group home.</p> <p>The Patient also completed an Advanced Directive on 3/23/2009, in which she established her sister as her spokesperson.</p>		

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S 146	<p>Continued From page 2</p> <p>and OT documented the discharge from services again on 4/8/09. PT documented "patient participates poorly and intermittently" and that zero progress had been made as of 4/8/09.</p> <p>Review of the physician progress note revealed the physicians continued to document that Patient #1 was deconditioned and she was participating in PT and OT after 3/31/09.</p> <p>The nursing notes and flow sheets for Patient #1 were reviewed and revealed she used oxygen from 2-3 liters intermittently. On 4/7/09, the nurse documented Patient #1 required the assistance of two to ambulate. On 4/8/09 - 4/9/09, Patient #1 ambulated with a walker and gait belt assistance. Record review failed to reveal Patient #1 was independent in ambulation prior to her discharge.</p> <p>The discharge plan for Patient #1 was to be transported to a women's homeless shelter in California. Patient #1 was in agreement with the plan. Patient #1's sister was notified of the discharge plan.</p> <p>Interview with the discharging nurse revealed Patient #1 was able to "stand and pivot" and to walk a few steps on the day of her discharge, 4/10/09.</p> <p>Review of the record failed to reveal either a wheelchair or walker was provided for Patient #1 at her discharge. The social worker confirmed neither was ordered for Patient #1 prior to her discharge. The social worker reported the patient continued to refuse SNF placement and was in agreement with the discharge plan. Review of the record revealed documentation of multiple conversations with the California case manager who advised Patient #1 needed to be referred by</p>	S 146	<p>Plan of correction NV 00021724 Tag S146, continued Page 3 of 4 (a)</p> <p>The Manager of Integrated Care Management has communicated via 9/1/09 Memo to the Hospitalist supervisor. The memo states that the Physical therapist documentation is clear in the notes of 3/31/09 that the patient was discharged from PT due to her lack of progress and participation and that patient was discharged for OT on 4/08/09. The memo further states: "I would ask that the providers review the therapy notes and refer to them in their progress notes. As it is documented, it <b>appears</b> that the provider was not aware that these services were discontinued due to lack of progress, participation and motivation on the patient's part." (Exhibit A)</p> <p>The Hospitalist Supervisor will review the medical record documentation and coach the individual provider with opportunities for documentation improvement, in addition, will meet with and reinforce with all hospitalist providers the necessity for accurate and consistent documentation. The Hospitalist Supervisor will complete by October 1, 2009.</p>		

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S 146	<p>Continued From page 2</p> <p>and OT documented the discharge from services again on 4/8/09. PT documented "patient participates poorly and intermittently" and that zero progress had been made as of 4/8/09.</p> <p>Review of the physician progress note revealed the physicians continued to document that Patient #1 was deconditioned and she was participating in PT and OT after 3/31/09.</p> <p>The nursing notes and flow sheets for Patient #1 were reviewed and revealed she used oxygen from 2-3 liters intermittently. On 4/7/09, the nurse documented Patient #1 required the assistance of two to ambulate. On 4/8/09 - 4/9/09, Patient #1 ambulated with a walker and gait belt assistance. Record review failed to reveal Patient #1 was independent in ambulation prior to her discharge.</p> <p>The discharge plan for Patient #1 was to be transported to a women's homeless shelter in California. Patient #1 was in agreement with the plan. Patient #1's sister was notified of the discharge plan.</p> <p>Interview with the discharging nurse revealed Patient #1 was able to "stand and pivot" and to walk a few steps on the day of her discharge, 4/10/09.</p> <p>Review of the record failed to reveal either a wheelchair or walker was provided for Patient #1 at her discharge. The social worker confirmed neither was ordered for Patient #1 prior to her discharge. The social worker reported the patient continued to refuse SNF placement and was in agreement with the discharge plan. Review of the record revealed documentation of multiple conversations with the California case manager who advised Patient #1 needed to be referred by</p>	S 146	<p>Plan of correction NV 00021724 Tag S146, continued Page 3 of 4 (f)</p> <p>An in-service, by the Integrated Care Management Manager, for all Integrated Care Management Staff, on Discharge Planning was held on 7/16/2009. Evidenced by sign in sheet (Exhibit J) All Integrated Care Management staff were provided with a Power Point presentation "Discharge Planning" (Exhibit K), as well as, information on the Conditions of Participation regarding Discharge Planning (as found in the State Operating Manual pp.293 - 306)</p>		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>NVN635HOS</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/02/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>CARSON TAHOE REGIONAL MEDICAL CENTE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1600 MEDICAL PARKWAY CARSON CITY, NV 89703</b>		
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S 146	<p>Continued From page 3</p> <p>her primary physician in California for them to place her in a California facility.</p> <p>On 4/10/09, Patient #1 was transported from the facility to a women's shelter in California by a transport van. Statements by the driver and attendant were reviewed and revealed Patient #1 did not want to get out of the van when they arrived at the shelter. The driver and attendant persuaded Patient #1 to go into the shelter, and helped her into a chair, and left her with her belongings at the shelter.</p> <p>On 4/10/09, Patient #1 was admitted to an acute care hospital in California with encephalopathy. The discharge summary from the facility documented Patient #1 was admitted with extreme weakness and inability to care for herself. On discharge, 5/4/09, it was documented Patient #1 was able to walk 200-300 feet unassisted.</p> <p>Severity 3 Scope 1</p>	S 146			

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